

HSRS
FAMILY SUPPORT PROGRAM MODULE

Child and Family Information

Screen 59 New or 84 Update

MODULE TYPE 5

1 Worker ID		2 Client ID		3 MA Number / Social Security Number		
4a Last Name			4b First Name		4c Middle Name	4d Suffix
5 Birthdate (mm/dd/yyyy)		6 Sex F M	7a Hispanic / Latino Y = Yes N = No	7b Race (Circle up to 5) A = Asian B = Black or African American P = Native Hawaiian or Pacific Islander I = American Indian or Alaska Native W = White		
(Module Key:)						
8 Start Date		9 End Date		10 Closing Reason		11 Alternate Care Type (Required if closing reason is 44) 1 Foster care 2 Group home 3 Residential care center 4 Center developmentally disabled 5 Mental health institute 6 Nursing home
12 Client Characteristics		13 Diagnosis				
14 Assistance Needed for Personal Care 1 Child unable to help him / herself 2 Child needs assistance with some activities 3 Child does not need assistance				15 Limitations in Mobility 1 Child cannot walk 2 Child needs assistance in walking 3 Child does not need assistance in walking		
16 Limitations in Verbal Skills 1 Child is nonverbal 2 Child has very limited verbal skills 3 Child is fully verbal				17 Limitations in Cognitive Abilities 1 Child has severe developmental delays 2 Child has moderate / mild developmental delays 3 Child has no cognitive delays		
18 Emotional / Behavioral Issues 1 Child presents significant behavioral challenges 2 Child presents minor behavioral challenges 3 Child has no behavioral challenges				19 Medical Needs 1 Apnea monitor 2 Gastrostomy / tube feed 3 Tracheotomy 4 Oxygen dependent 5 Heart monitor 6 Acute psychiatric episode 7 Ongoing medications 8 Degenerative disorder 9 Surgery this year 10 Hospitalization this year		
20 Family ID	21 Number of Caregivers	22 Adopted Child Yes No		23 Parent's Special Needs 1 Developmentally disabled 2 AODA 3 Mentally ill 4 Physically disabled 5 Medical condition		
24 Income Range 1 0 - 10,000 2 10,001 - 15,000 3 15,001 - 20,000 4 20,001 - 30,000 5 30,001 - 40,000 6 40,001 +					25 Family Cost Share	

Screen 79

26 Has child returned from alternate care? <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes" enter alternate care type: 1 Foster care 2 Group home 3 Child caring institution 4 Center for developmentally disabled 5 Mental health institute 6 Nursing home					
27 Reporting Year Registration 0000		28 Has family considered out of home placement? Yes No		29 Is family in a crisis situation? Yes No	
		Yes No		Yes No	
		Yes No		Yes No	
		Yes No		Yes No	
		Yes No		Yes No	
		Yes No		Yes No	

EXPENDITURES FOR FAMILY SUPPORT SERVICES

Screen 93 (Module Key: _____)								30 Next Review Date
31 Other Programs Used 2 BCPN 4 SSI-E 6 Birth to 3 3 SSI 5 Katie Beckett			32 Voluntary Resources 1 _____ 2 _____					33 Target Group* * Refer to deskcard
Prog. No.	34 Subprogram	35 Estimated Annual Costs	36 Cost Code A - Add S - Subtract R - Replace	37 Actual Costs	38 Delivery (mm) (yyyy)	39 Service Start Date	40 Service End Date	41 Provider Number
	A Architectural modification of home							
	B Child care							
	C Counseling / therapeutic resources							
	D Dental and medical care not otherwise covered							
	E Diagnosis and evaluation - specialized							
	F Diet, nutrition and clothing - specialized							
	G Equipment / supplies - specialized							
	H Homemaker services							
	I In-home nursing services - attendant care							
	J Home training / parent courses							
	K Recreation / alternative activities							
	L Respite care							
	M Transportation							
	N Utility costs - specialized							
	O Vehicle modification							
	P Other, as approved by DHFS							
42 Subprogram P, text:								

* Refer to deskcard